

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/23/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/23/2013
Date of Injury: 12/24/2012
IMR Application Received: 8/5/2013
MAXIMUS Case Number: CM13-0007388

Dear Mr./Ms. [REDACTED]:

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [REDACTED]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgeon, has a subspecialty in Spine Surgery and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The physician reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

52 year old male with industrial injury 12/24/12. Report from 6/5/13 states patient with right knee pain. Report of popping, clicking and locking and report of medial joint line tenderness and positive McMurray's test. Patient status post 10 sessions of physical therapy and brace usage. MRI 2/13/13 demonstrates posterior horn medial meniscus tear and focal Grade 4 chondromalacia of medial patellar facet and osteochondral defect with loose bodies.

IMR DECISION(S) AND RATIONALE(S)

The Final Determination was based on decisions for the disputed items/services set forth below:

1. 12 post operation physical therapy sessions between 6/24/2013 and 8/26/2013 is not medically necessary and appropriate.

The Claims Administrator did not cite any evidence based criteria for its decision.

The Physician Reviewer based his/her decision on the Post-Surgical Treatment Guidelines, which is part of the MTUS.

The Physician Reviewer's decision rationale:

According to the California MTUS – Postsurgical Treatment Guidelines regarding post surgical physical therapy, "Initial course of therapy" means one half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations set forth in subdivision (d)(1) of this section. "Knee Dislocation of knee; Tear of medial/lateral cartilage/meniscus of knee; Dislocation of patella: Postsurgical treatment: (Meniscectomy): 12 visits over 12 week. Postsurgical physical medicine treatment period: 6 months." The request for 12 post operation physical therapy sessions between 6/24/2013 and 8/26/2013 is not medically necessary and appropriate.

2. 14 day rental of continuous passive motion device between 6/24/2013 and 9/26/2013 is not medically necessary and appropriate.

The Claims Administrator did not cite any evidence based criteria for its decision.

The Physician Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines (ODG), which is not part of the MTUS.

The Physician Reviewer's decision rationale:

Criteria for the use of continuous passive motion devices: In the acute hospital setting, postoperative use may be considered medically necessary, for 4-10 consecutive days (no more than 21), for the following surgical procedures:

- (1) Total knee arthroplasty (revision and primary)
- (2) Anterior cruciate ligament reconstruction (if patient care)
- (3) Open reduction and internal fixation of tibial plateau or distal femur fractures involving the knee joint (BlueCross BlueShield, 2005) for home use up to 17 days after surgery while patients at risk of a stiff knee are immobile or unable to bear weight.
- (4) Under conditions of low postoperative mobility or inability to comply with rehabilitation exercises following a total knee arthroplast or revision: this may include patients with:
 - a. Complex regional pain syndrome
 - b. Extensive arthrofibrosis or tendon fibrosis
 - c. Physical, mental, or behavioral inability to participate in active physical therapy
- (5) Revision total knee arthroplasty (TKA) would be a better indication than primary TKA, but either OK if #1 applies.

There is insufficient evidence of medical necessity for CPM following knee arthroscopy. Therefore the determination is for non-certification.

3. 90 day rental of SurgiStim unit between 6/24/2013 and 9/26/2013 is not medically necessary and appropriate.

The Claims Administrator did not cite any evidence based criteria for its decision.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The use of a SurgiStim unit is not addressed in this clinical scenario following a knee arthroscopy. As there is insufficient evidence regarding use in this clinical scenario, the determination is no non-certification. Regarding the Interferential Current Stimulation (ICS), the California MTUS Chronic Pain Medical Treatment Guidelines state, "Not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain,

soft tissue shoulder pain, cervical neck pain and post-operative knee pain. The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues. In addition, although proposed for treatment in general for soft tissue injury or for enhancing wound or fracture healing, there is insufficient literature to support interferential current stimulation for treatment of these conditions. There are no standardized protocols for the use of interferential therapy, and the therapy may vary according to the frequency of stimulation, the pulse duration, treatment time and electrode placement technique.

4. Coolcare cold therapy unit is not medically necessary and appropriate.

The Claims Administrator did not cite any evidence based criteria for its decision.

The Physician Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines (ODG), which is not part of the MTUS.

The Physician Reviewer's decision rationale:

ODG Continuous-cold cryotherapy

According to the Official Disability Guidelines regarding cold therapy, "Continuous-flow cryotherapy: Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. The available scientific literature is insufficient to document that the use of continuous-flow cooling systems (versus ice packs) is associated with a benefit beyond convenience and patient compliance (but these may be worthwhile benefits) in the outpatient setting his meta-analysis showed that cryotherapy has a statistically significant benefit in postoperative pain control, while no improvement in postoperative range of motion or drainage was found. As the cryotherapy apparatus is fairly inexpensive, easy to use, has a high level of patient satisfaction, and is rarely associated with adverse events, we believe that cryotherapy is justified in the postoperative management of knee surgery. There is limited information to support active vs passive cryo units. Aetna considers passive hot and cold therapy medically necessary. Mechanical circulating units with pumps have not been proven to be more effective than passive hot and cold therapy. This study concluded that continuous cold therapy devices, compared to simple icing, resulted in much better nighttime pain control and improved quality of life in the early period following routine knee arthroscopy. Two additional RCT's provide support for use after total knee arthroplasty (TKA). Cold compression reduced blood loss by 32% and pain medication intake by 24%. It improved ROM and reduced hospital stay by 21%.

5. Pre operation medical clearance is not medically necessary and appropriate.

The Claims Administrator did not cite any evidence based criteria for its decision.

The Physician Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines (ODG), which is not part of the MTUS.

The Physician Reviewer's decision rationale:

Per ODG, Preoperative testing (e.g. chest radiography, electrocardiography, laboratory testing, and urinalysis) is often performed before surgical procedures. These investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, co morbidities, and physical examination findings. Patient with signs and appropriate testing, regardless of the preoperative status. Electrocardiography is recommended for patients undergoing high-risk surgery and those undergoing intermediate risk surgery who have additional risk factors. Patients undergoing low-risk surgery do not require electrocardiography. In this patient the decision for knee arthroscopy is defined as a low risk procedure and does not require preoperative medical clearance.

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.

[REDACTED]

CM13-0007388